PRINTED: 06/22/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		DNSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185039	B. WING				C / 29/2015
NAME OF PI	ROVIDER OR SUPPLIER	1		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 10/	29/2015
				1705	STEVENS AVENUE		
HIGHLAN	DS HEALTH AND REHAI	BILITATION CENTER		LOU	JISVILLE, KY 40205		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
F 282 SS=D	and concluded on 10 complaint KY 23982. unsubstantiated the a deficiencies cited. 483.20(k)(3)(ii) SERV PERSONS/PER CAFT The services provider must be provided by	The Division of Health Care allegation with unrelated /ICES BY QUALIFIED RE PLAN d or arranged by the facility	F	282			
	by: Based on observation and facility policy revision facility failed to follow five (5) sampled resident	· · · · · · · · · · · · · · · · · · ·					
	Coordinator, on 10/29 she followed the RAI followed. Review of the page 4-11, #12, reverse approaches that wou resident achieve his capproaches serve as care and provide for the she followed in the serve as the se	nimum Data Set (MDS) 8/15 at 11:33 AM, revealed and that was the policy she ne MDS 3.0 Section 4, 4.7, aled the Interdisciplinary fic, individualized steps or ld be taken to help the or her goals. These instructions for resident the continuity of care by all noise instructions help staff					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	'		TITLE		(X6) DATE

11/20/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 100218

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		185039	B. WING			C 10/29/2015
NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 1705 STEVENS AVENUE LOUISVILLE, KY 40205	ODE	10/23/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	The state of the s	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	Review of Resident the facility admitted diagnoses of Paral Obesity, Edema an Review of Resident Set (MDS Assessm the facility assessed Interview for Menta fifteen (15) which minterviewable. Review of Resident Plan, dated with a prevealed Resident # contractures and ed Resident # a would skin breakdown due contractures. The inprovide foot care. Interview with Resident Plan, revealed his/he Nurse Practitioner's Podiatrist come to smonths ago and it have reconsidered to the provide foot says and the review of Resident 109/08/15 (51 days a Podiatry Consult as right great toe for Parallel Plans and Parallel Plans and Pla	ge 1 blement interventions. #3's clinical record revealed the resident on 06/10/15 with Polio, Muscle Weakness, d Lack of Coordination. #3's Quarterly Minimum Data ent, dated 09/15/15, revealed d Resident #3 using a Brief I Status (BIMS) and scored a heant the Resident was #3's Comprehensive Care problem onset of 06/30/15, and bilateral foot drop, dema. The goal stated not have adverse effects or ent to the bilateral foot drop and intervention was for staff to the dent #3, on 10/27/15 at 2:05 are feet were infected and the stated she would have the see him/her about two (2) and not occurred as of yet. #3's Physician Orders, dated ago), revealed an order for a se soon as possible (ASAP), to aronychia (an infection that edge of the fingernail or	F	282		
	10:35 AM, revealed was observed to ha	ident #3's feet, on 10/29/15 at I Resident #3's right big toe we dark red and yellow scab in ail. The right third (3rd) digit				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185039	B. WING _		10	C 0/29/2015	
NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, Z 1705 STEVENS AVENUE LOUISVILLE, KY 40205	•	0/23/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE	
F 282	toe was observed bed of the toe nail observed to be sw Interview with Lice on 10/29/15 at 10: staff initiated the cadmitted and could orders were ordered. Coordinator and the (ADON) were respected plan. LPN #1 follow the care plan. LPN #1 follow the care plan when assessment of the Coordinator stated the care plans bed the residents. The measure for provide the care plan. Interview with the AM, revealed staff care plan. The AD was a nursing measure directed by the Interview with the 10/29/15 at 11:45 stated the staff was part of that foot care, expected to follow	e yellow in color. The left big to have a black scab on the . Both feet and shins were ollen. Insed Practical Nurse (LPN) #1, 35 AM, revealed the nursing are plan when a resident was dupdate the care plan as new led. LPN #1 stated the MDS are Assistant Director of Nursing ionsible for the comprehensive stated staff was expected to in. MDS Coordinator, on 10/29/15 aled she became involved with in she completed the admission resident. The MDS at staff were expected to follow cause it was the plan of care for Podiatrist order was a nursing ding the foot care as stated on ADON, on 10/29/15 at 10:52 were expected to follow the ON stated the Podiatrist order asure for providing the foot care		309			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ı	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		185039	B. WING		C 10/29/2015		
NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	10/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC		
F 309 SS=D	provide the necessal or maintain the highe mental, and psychos	receive and the facility must ry care and services to attain est practicable physical,	F 30	09			
	by: Based on observation review, it was determ follow the physician of sampled residents, (to follow the order for on 09/08/15, 51 days as possible (ASAP). The findings include: The facility did not prophysician orders. Review of Resident of the facility admitted the facility admitted the facility, Edema and Review of Resident of Set (MDS) Assessment facility assessed Interview for Mental						

	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
	185039	B. WING _			C 10/29/2015		
	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1705 STEVENS AVENUE LOUISVILLE, KY 40205	CODE	10/20/20 10		
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
Interview with Resident #3 stated Nurse Practitioner is Podiatrist come to shad not seen the podiatrist come to shad not seen the podiatry Consult As Paronychia (An infeedge of the fingernal Interview with Resident #3's feet, revealed Resident ared and yellow scal right third (3rd) digit big toe had a black nail. Both feet and shall. Both feet and shall be would cut his/her nail. LPN #1 stated that ASAP m because something be seen.	dent #3, on 10/27/15 at 2:05 the did not have pressure ther feet were infected. About two (2) months ago the said she would have the see him/her; however, he/she odiatrist as of yet. 2.#3's Physician Orders, dated ago), revealed an order for SAP to right great toe for ection that develops along the ail or toenail). 3.#3's right big toe had a dark of in the bed of the toe nail. The at was yellow in color. The left acab on the bed of the toe shins were swollen. Resident and a family member to cut acause no one from the facility ails. 3.#3's right big toe had a dark of in the bed of the toe shins were swollen. Resident and a family member to cut acause no one from the facility ails. 4.#3's right big toe had a dark of in the bed of the toe shins were swollen. Resident and a family member to cut acause no one from the facility ails. 4.#3's right big toe had a dark of in the bed of the toe shins were swollen. Resident and a family member to cut acause no one from the facility ails. 4.#4 About 1.#4	F	309				
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	SUMMARY (EACH DEFICIENT REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY OF RESIDENT RES	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Interview with Resident #3, on 10/27/15 at 2:05 PM, revealed he/she did not have pressure though both of his/her feet were infected. Resident #3 stated about two (2) months ago the Nurse Practitioner said she would have the Podiatrist come to see him/her; however, he/she had not seen the podiatrist as of yet. Review of Resident #3's Physician Orders, dated 09/08/15 (51 days ago), revealed an order for Podiatry Consult ASAP to right great toe for Paronychia (An infection that develops along the edge of the fingernail or toenail). 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LPN #1 stated that ASAP meant as soon as possible because something was going on that needed to	ROVIDER OR SUPPLIER DS HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Interview with Resident #3, on 10/27/15 at 2:05 PM, revealed he/she did not have pressure though both of his/her feet were infected. Resident #3 stated about two (2) months ago the Nurse Practitioner said she would have the Podiatrist come to see him/her; however, he/she had not seen the podiatrist as of yet. Review of Resident #3's Physician Orders, dated 09/08/15 (51 days ago), revealed an order for Podiatry Consult ASAP to right great toe for Paronychia (An infection that develops along the edge of the fingernail or toenail). 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		185039	B. WING				C 29/2015	
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F 309	building the staff kne message. She stated make the Podiatrist a Interview with the As (ADON) on the seco 10:52 AM, revealed Records did not obta stated Resident #3 v came in to clip his/he ingrown nail. Reside applied antibiotic oin ADON stated she ve not having family con ADON stated Reside swollen, but they we appearance. Interview with Reside Registered Nurse (APM, revealed Parony	s stated if she was not in the w to call her and leave a d she was responsible to	F	3309				
	needs to be opened stated the facility did or she would have re The APRN stated sh because she meant appointment as soor could have sent Res Room, but that would when the Podiatrist of APRN stated she wanot follow through winursing staff did not order should be disc member had come to	and drained. The APRN not carry numbing medicine elieved the pressure herself. e wrote the order ASAP for the facility to make the as possible. She stated she ident #3 to the Emergency d have been a waste of a bill, could do the procedure. The as not aware the facility did th the order. She stated call her to inform her the ontinued or that a family						

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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		10/29/2015
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F 309	10/29/15 at 11:45 AM aware Medical Recor the order for the Podi should have made su up on as prescribed.	I, revealed she was not rids was not made aware of latrist. The Nursing staff are the orders were followed The DON stated there discontinue order if the family	F3	309		